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Explorations in Medical Anthropology & Health Sciences

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CONTENTS

Health, Disease and Health Care

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Health is usually understood as absence of disease. In that sense, health is discussed as a medical concept giving prominence to disease control program and medical profession. Since disease control program which has a global perspective and linkage with the pharmaceutical industry, disease control programs get precedence over health prevention and promotion activities. India shares the global concerns of chronic, stigmatizing diseases such as Leprosy, HIV/AIDS and TB. The national health concerns relate to child and women's health. In India, we have inherited plural systems of medicine such as Allopathy, AYUSH etc. Besides, we have special issues of tribal health. Health and disease are also moral issues. A healthy person and a person who gets quick death are considered to be morally superior to those who suffer from chronic ailments and have to pray for release from suffering if they remain bed ridden for a long time. A disease is therefore considered deviance from morality. Chronic diseases like leprosy, HIV/AIDS and TB are stigmatizing and get associated with the idea of sin, either in this birth or past birth.

Human communities are interested in health and disease cure of its members. In the animal world, sick are left to use their own resources for recovery or die. Amongst human beings, members of the group attempt to restore sick person to health, to enable him to perform normal role obligations. It is believed that in case of leprosy in the past centuries where recovery was considered impossible, the sick were left to fend for

themselves. One of the methods was to invoke divinity to help such persons, and to feed them to prevent death from starvation.

Medical systems have developed as a vast complex of knowledge, beliefs, techniques, roles, norms, values, ideologies, attitudes, customs, rituals and symbols, in short, a totality of health knowledge, beliefs, skills and practices of the members of every group. In short, a medical system embraces all of the health promoting beliefs and actions and scientific knowledge and skills of the members of the group that subscribe to the system. Every society has its own concepts of health, disease causation and health care. Usually, health is understood by lay people as a totality of appetite for food, body metabolism, good sleep, and body-mind vitality to perform social roles.

Conceptually, techniques and tools that provide cure or relief from symptoms are easily acceptable from any medical system as they fall into the realm of soft aspects of culture or material aspects of culture. Issues of causality of the disease or concepts of body, mind, soul, intellect and their inter-relationship with external environment fall into the realm of hardcore of culture relating to the belief systems which are not easily penetrable. People can take pragmatic action for relief and cure without changing the belief system. People can accept technology without accepting science, and without imbibing the scientific temper.

There can be conceptual difference between disease, a pathological concept and illness, a cultural concept. Usually, a person with disease is treated to cure his illness. The tragedy of leprosy is that a person is labelled as a patient but not as a sick person. He does not get the status of sick person who is freed from performance of social roles. Actually, that is the

malady of the chronic disease. In leprosy, a patient is not cured but only released from treatment, he never becomes a person but remains an ex-patient signifying the possibility of his becoming a patient again.

Diseases are classified according to modern biomedical concepts in terms of transmission process, namely, communicable and non-communicable. Biomedical solutions for individual cure and public health issues are in terms of chemotherapy and vaccines to deal with causative organisms. Traditionally, medical systems have a three fold classifications: (a) curable, (b) curable with sustained effort and (c) incurable. Lay people have only two categories, curable and non-curable. They also understand the issues of mortality and morbidity. Action is taken for the symptoms which causes morbidity affecting social and economic life to get relief in order to become normal. Leprosy, although curable in biomedical sense, continues to be a problem since the biomedical paradigm and people's paradigm do not meet each other. Leprosy Elimination Campaigns (LEC) continues to target lowering prevalence with a hope of decreasing incidence in a reasonably short period. Health education, now called IEC is aimed at operationalising this paradigm. It required considerable efforts on the part of medical anthropologist to include the third objective to leprosy control as given in the WHO document TRS 716 of 1985, to include' prevention of associated deformities' Similarly, the Sixth Expert Committee on WHO in TRS 768 of 1988 modified the definition of a case of leprosy to include the patients who completed treatment and were under surveillance and those who had deformities and disabilities needing rehabilitation.. LEC even after involving some volunteers from the community have

tried to widen coverage for quick case detection, termed in India as MLEC. Number of cases with disability grade 1 and 2, among new cases is alarming. In one block in eastern Madhya Pradesh, out of 68 newly detected cases, 25 had grade 1 and 2 disability, in the report dated October 2001.

Health education has stressed two points:

(1) To identify leprosy by patches and not necessarily by deformity, thereby brining the stigma of leprosy to patches atleast among the educated people.

(2) To tell the people that leprosy is a curable disease and that early diagnosis and regular treatment would prevent the onset of deformities.

Health education does not inform the people as to why some people get leprosy and others do not get affliction, and the process of getting ulcers and deformities. Lay people have the experience of identifying and suffering leprosy due to disabilities for 5000 years against the input of the MDT for the last 15 years. Attitudes are formed or changed by experience and not by partial information in IEC material aimed at motivating people to comply with the biomedical paradigm. Statistics, that is measurement of prevalence is a good tool in the programme. But lay people go by disability than by numbers of leprosy labelled patch patients. One disabled person in a village continues the stigma and fear, against 10 patch cases who have completed their treatment and have become RFT.

People's paradigm of leprosy control relates to freedom from fear of leprosy and not infection of leprosy. They can classify the villages and grade them according to the degree of success achieved. The indicators are level of participation in the family

and community such as no divorce on account of leprosy, no denial of civic facilities, and full participation in the economic activities. This freedom from fear could be achieved by campaigning about management of impairment and prevention of disabilities. This needs a constant and simultaneous dialogue with the community, family and the patients. RFT persons, opinion leaders from the community, the patient and the health workers have to form joint teams for these campaigns. We have experience of several volunteers from the villages, more particularly women volunteers who take initiatives in case detection, case holding and disability prevention work. People have to get experience that impairment and disability are preventable, ulcers are curable. They have to know that ulcers and disability are no leprosy but the result of non-treatment of leprosy and an apathy towards self-care. This is possible by organising ulcer care and skin diagnostic camps in the community in preference to doing these activities in hospital wards. Community, family and patient counselling session have to be organised in the villages and homes and not only in OPD.

In the female ward of TLM Naini hospital at Allahabad, it was found that the young married women had come from their mothers' house and not from their husband's house. This data was not enquired and recorded on the case sheet. The community, patient and family have to get total knowledge about the disease process and not only the messages of curability. What is the difference between the biomedical definition of cure and people's concept of cure in leprosy? To which concept is our programme aimed at? Unless it addresses itself to the concerns of people, it cannot meet with success. The programmers have to take initiatives in addressing its

programmes to people's concerns and prepare the packages on health education to answer the question people have in mind. The matter has to be taken seriously and not be brushed aside as ignorance, illiteracy, superstition. It may take years to change the belief system in regard to a disease due to scientific ignorance about human immune system and unanswered epidemiological gaps in knowledge. People are always willing to take treatment for their morbidities. They are willing to discuss transmission at the level of family, kin group, neighbourhood and village, and are willing to volunteer for diagnosis if morbidity is preventable.

To put briefly, from the anthropological perspective, it is necessary to find out the methods of changing the behaviour and practices of health personnel instead of targeting only people. People have to be provided with experience of care and cure as per their perceptions and not the biomedical perceptions to help to change their attitudes and behaviour. Stigma of leprosy is due to the experience of infectivity for hundreds of years which is not curable, and which leads to social exclusion and non-participation as members of groups. Leprosy workers have to come out of the institutions and mix with the community providing examples of prevention of impairment and disability. The number of people diagnosed, put on treatment and released from treatment or control, does not impress the local communities, since these cases are not the same leprosy, as known to communities since ages. Leprosy programme in the public and voluntary sector in leprosy have to show the way to take out the humanity from the grip of fear and ignorance about getting deformities and ulcers as a result of ignoring the signs and symptoms of disease and due to irregular treatment..

Tribal Health

Health care delivery in tribal regions is organized on the same lines as for the main stream society except that the populations covered by health care institutions are lesser in tribal pockets. It is however not realized that the tribal people have been cared for by the ethnomedical professionals with the use of herbal medicine for centuries. They are dismissed by the government program as quacks except for the dais. Thus, the macro health-care infrastructure is installed in the tribal belt without interacting with the micro structures available. Although the government treats all plurals systems as equal, in practice, AYUSH is rated low in status. It is publicly announced that AYUSH graduates would be appointed in tribal areas if allopaths are not available to man the health centres.

In Maharashtra, out of thirty five districts, Nandurbar district ranks thirty fifth according to human development index calculated by the state government. Nandurbar is a tribal district, with 75% tribal, rural population. Why should a tribal district be the most backward with all the tribal development schemes being implemented?

There are certain policy issues involved in tribal development. Since S.T. population in Maharashtra is 9%, the tribal development department is supposed to get 9% of the state budget. Although in practice the department never gets 9% budget, the department only acts as post office to distribute the budget to sector, line departments such as health, education etc. The department has no authority to monitor the expenditure or out come of the budget. There are several schemes of tribal development about which people are totally ignorant.

We had recommended to the government to position the

sector department officials of the level of Deputy Director or Joint Director in tribal development department for effective monitoring of various schemes. This would facilitate the coordination between all departments and activities to bring out the comprehensive and holistic perspective. The participant observation of secretary level meetings chaired by the Chief Secretary clearly bring out the bureaucratic implementation of schemes only through government employees at all levels from district to village level. Never a mention is made of the role of panchayati raj institutions and personnel.The Collector-cum judicial magistrate is superior in civil services rank than a Chief Executive Officer who heads the development administration of Zila Parishad.. So, what are the priorities, revenue or development? Similarly, the Director of Ayurved has no public health function, only authority to monitor the AYUSH medical colleges. Who then supervises the health care functions of AYUSH personnel at the primary health care centres, other than the seniors from allopathic system?

Most of the rural development schemes function through the institution of grampanchayat. However most of the grampanchayats in tribal area are multi village institutions. Actually the revenue village in tribal belt which may be a conglomeration of hamlets inhabited by specific tribal ethnic groups is not a functioning unit. The functioning unit is the hamlet. As a result, village based institutions such as school and anganwadi do not cater to the needs of people living in hamlets.Like the dominant caste, there are also dominant tribal ethnic groups based on socio-economic considerations which become co-terminus with educational standards. Even the political leaders are not interested in division of group grampanchayats into single village grampanchavats since

decentralization of power reduces their centralised authority.These issues at the government and democratic levels reduce the PRI to non-functioning entities.

In health sector it is necessary to use the services of herbalist medicine man and dai for providing the services to the people. Their knowledge and skills could be updated for better result.

These recommendations have evolved from the ethnographic knowledge of tribal culture from field work experience in anthropology. Ethnography in classical anthropology referred to the description of culture traits, patterns and complexes. In the era of planned, directed change, it is necessary to have the interaction of macro level policies and programs with micro level logistics rooted in the culture of the people. This is what Jawaharlal Nehru meant when he said that the change should be according to the genius of the people. It is therefore necessary to redefine the anthropological understanding of holism. Holistic approach can no more be limited to the holistic and integrated understanding of the culture of an ethnic group. It should refer to the understanding of macro-micro dynamic interaction which can bring about sustainable cultural and social change.

These two examples of the stigmatizing chronic disease of leprosy and the issues about tribal health clearly bring out that health and disease are to be understood from people' perspective. However, the totality of action has to be understood in terms of macro-micro interaction giving due credence to the global, national policies, the available technologies and health care infrastructure at the local level and in the public and private sector. The experience of leprosy would be useful in dealing with HIV-AIDS, since the communities are stigmatising HIV+ in the same manner as they treated leprosy afflicted.

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Medical Anthropology
Past, Present and Future

Paper presented at National Conference on "Medical Anthropology and Health Sciences", Mysore.

This is an occasion for me to go down the memory lane. As a master's level student at Sagar during 1957 – 1959, Prof. S.C. Dube taught us applied anthropology. The applications given in the text books related to 'golden stool' incident among African tribes and some references as to why Zulu were not using the toilets constructed for them. The only references available about applied anthropology in medicine were William Caudill's paper in Anthropology Today by Kroebar and Benjamin D Paul's edited book of case studies, besides writings of Margarate Mead. After joining Pune University at the Deccan College Post-graduate Research Institute in 1960, Prof. Iravati Karve directed me to deliver some lectures to the post graduate students of preventive and social medicine at the Armed Forces Medical College Pune in 1963, the series having continued for more than three decades. This followed an invitation from the civilian B.J. Medical College, Pune. The teaching of medical anthropology at Pune which started in 1974 had its beginnings in the interaction with these medical institutions. In 1967, I was called upon by Gandhi Memorial Leprosy Foundation, Wardha to participate in the training programme for their health education officers at the B.J. Medical College. This began my association in the field of leprosy which continues today. I got the opportunities to influence WHO leprosy control policies about the social aspects of leprosy.

It is this background which made it possible to organize the post-plenary session on medical anthropology of the

International Anthropology Congress in December 1978 at University of Pune. Prof. H.K. Bhat and Prof. P.C. Joshi were the delegates at this symposium. Among others, the symposium was attended by Prof. A.L. Basham, Prof. Charls Leslie, Prof. Arther Kleinman, Prof. Clark Cunningham, Prof. Ronald Frankenberg, Dr. Judith Justice and Prof. Mark Nichter. The doyen of Ayurved, Vaidya Pandit Shiv Sharma also attended the symposium which provided the first international platform to Ayurved.

The participation by Prof. Basham and Pandit Shiv Sharma with Charles Leslie paved the way for establishing the Indian chapter of International Association for the Study of Traditional Asian Medicine (IASTAM) in April 1980 at a meeting hosted by the Department of Anthropology at Pune. This continues to provide opportunities in interacting with the department of AYUSH, Government of India.

The experience of stigmatized disease of leprosy has initiated to work in another stigmatized conditions of HIV/AIDS in the current scenario. Our academic NGO, Maharashtra Association of Anthropological Sciences is currently the Asian partner of London School of Tropical Hygiene and Medicine and involved in HIV-TB research. We have been granted an intervention project on Comprehensive and Sustainable Human Development of the Tribal people of Maharashtra, jointly with Comprehensive Rural Health Project of Padmabushan Dr. R. S. Arole, by Government of Maharashtra.

Medical Anthropology at Pune University helped in the establishment of the Inter- Disciplinary School of Health Sciences which has now initiated a School of Public Health sponsored by the UGC. The University of Pune made a history by appointing

me from the social science faculty to be the first Professor and Director of the School of Health Sciences in the science faculty. The University has continued the tradition by appointing me as the Chairman of the Board of Studies in Health Sciences and as Member of the Academic Council. Ph.D. level research in areas of medical anthropology has been conducted, both in anthropology and health sciences.

Anthropology as a holistic study of man has developed out of the studies of isolated people, following the ethnographic model. Following the same model, health issues of tribal people have been studied by the anthropologists which forms the bulk of medical anthropology. There has been a confusion between classifying research in anthropology and ethnology. Similar confusion might appear in the areas of Medical Anthropology and Ethnomedicine. In leprosy, research projects submitted to ICSSR or ICMR are focussing on the study of leprosy villages, that is, leprosy asylums which isolate the leprosy afflicted rejected by the society. These researches make no dent on the issues of leprosy control programme.

Medical anthropology has been defined in various terms such as:

1. Bio-cultural understanding of man and his works in relation to health and medicine.
2. Encompasses the state of medical phenomena as they are influenced by social and cultural features and social and cultural phenomena, as they are illuminated by their medical aspects.
3. Medical anthropologists describe their work relating to (a) research about description and interpretation of bio-

cultural interrelationships between human behaviour, health and disease levels, (b) their professional participation in health improvement programmes and programmes about changing health behaviour to promote better health.

Most of the books under the title Medical Anthropology have published papers relating to beliefs and practices of isolated communities or the folk practices of traditional peasant communities. Similarly, most of the papers presented in Anthropology seminars relate to ethnographic accounts of health behaviour practices and functioning of local health practitioners. There is description, no analysis in terms of theory or policy planning. Even the textual great health traditions of India and China, namely Ayurved and Chinese Medicine have been discussed under ethnomedicine in Medical Anthropology by Foster and Anderson. Actually, I discussed this matter with George Foster who accepted my argument.

Instead of discussing the practices and knowledge of shamans and herbalists under ethnomedicine, it would be more appropriate to discuss under the conceptual framework of little tradition and great tradition enunciated by Robert Redfield. The interaction between little and great tradition in India is obvious since the classical texts are generalizations of the folk practices, as are evident in home remedies and kitchen medicine. Similarlly the concept of anatomy and physiology in Indian and other traditional systems of medicine discuss metabolism and immunity. The concept of Shukra and Ojas are the guiding principles about masculinity which hinder vasectomy to the extent of Indira Gandhi loosing political power.

Medical anthropology is applied anthropology about health aspect of culture. It is now common knowledge that applied

anthropology was rated low in anthropology. George Foster accepted that his teachers, Herskovits, Kroebar and Lowie had successfully inoculated him against the germ of applied work, since it did not contribute to anthropological theory. Foster countered this argument by the fact that much of culture change theory came from materials collected through applied anthropology. I have gone through this process myself since I was laughed at for hobnobbing with medical personnel. On the other hand, medical professionals made critical comments about the postmortem evaluation of their programmes instead of participating in implementing them. We are aware that after the third world countries became independent and aspired for welfare and development of the people, the expectations from intellectuals and academicians to contribute to the development process were high. In India, after the community development programme was embarked in 1952, which included the installation of primary health care in rural areas, several anthropologists from Western Countries came as consultants to design extension strategies in community development. Anthropologists and later professional social workers, were called upon to educate the illiterate people to adopt agricultural and health technologies for their development. We are aware that curative medical technologies from all systems of medicine have been accepted by the people but not those in the preventive and promotive aspects which contradict the basic cultural norms and values. Female foeticide and age at marriage of girls do not show any change for the better. Vasectomy continues to be unacceptable. Condom is not used in marriage as safe sex tool to prevent HIV. Condom is not used widely between a female sex worker and her frequent client, with whom an emotional relationship has developed. Anthropologists understand the

rationale of these behaviour patterns.We explain seemingly contradictory behavior with the use of concepts of hard and soft core of culture. However health education programmes having gone through the terminological change to IEC seems to be asserting on behavioural change communication to which anthropologists are supposed to contribute. The whole paradigm of health programmers is to get the people to accept what is offered to them by medical model to solve people' s problems created by powerful agents in the epidemiological triangle. They want anthropologists to help them in this social marketing to accept and convince them as to how slight behavioral change will solve the problems created by bacilli and viruses.

The paradigms of health programmes are medicalised, in many cases governed by distribution of medical products coming from the pharmaceutical industry. These programmes therefore do not address to people's concerns. For example, leprosy afflicted are concerned about social exclusion as a result of deformity, mutilation and ulcer. The programme is concerned about identifying the bacillus and killing it. Since deformity is caused by nerve damage, anthropological perspective of priority medical research should be in the area of nerve damage in preference to drug research. HIV/AIDS conveys that HIV and AIDS are synonyms which they are not. Any counseling to HIV+ve person that AIDS could be postponed by pursuing healthy life style does not make any impact on the mind.

The argument is that the medical anthropologist should address the issues of policy planning significance, using anthropological theory and research tools. The strength of anthropological research lies in qualitative methods which answer the question 'why'. The Ford Foundation had in February 1990

organised a qualitative field research workshop in the villages under AIIMS around Delhi for the institution research staff who had received grants from Ford Foundation in RCH. I had the privilege of doing field work with Dr. Pelto and make presentations as a resource person. This interaction developed in Ford Foundation granting a big programme on Sexuality and Sexual Behaviour to the School of Health Sciencs at Pune University.Medical Anthropologists are now involved in sexuality research, including HIV-AIDS.The ethical issues relating to HIV related research also needs anthropological interventions since several cultural issues are relevant in multi-national studies.

The national surveys such as NFHS, NSS and Census provide the quantitative data necessary for policy planning and budgeting. However the micro level planning, implementation and logistics is not possible without supplementing it with qualitative data. Addressing the policy planning issues does not necessarily mean involvement in intervention. On the other hand, intervention can be transformed into intervention research which could throw leads to theory formulation. It is common knowledge for anthropologists that the interventions if addressed to the concerns of the people would provide meaningful outputs and would move towards sustainability by becoming a part of culture pattern. Similarly the knowledge of integrated nature of culture, soft core changing faster than the hard core, would provide leads in appropriate planning of intervention for culture change. The strategy of 'Going Native' for establishing Rapport in field research is an exercise in confidence building for micro-planning and implementing intervention with community involvement. Mahatma Gandhi associated himself by identifying himself with the Daridranarayan by putting on their clothes and by visibly living like them. He had the genuine compassion for them. We

are aware that anthropologists develop an emotional attachment to tribal people they study if they have really lived with them and indulged into participant observation. Cross cultural research and comparative method are recommended to shed away the danger of subjectivity and inculcate objectivity.

Medical Anthropology has bright future in India. From the one department at Pune in 1974, almost all departments of Anthropology in India want to have formal courses in Medical Anthropology. Medical Anthropology is more in demand at the ICMR and now at the AYUSH department of Government of India due to objectivity of Anthropology to plural systems of medicine and its usefulness from people's curative, preventive and promotive perspectives. Several anthropologists are employed in ICMR institutes, who need to be brought to SIMA.

We should be ready to interact with the medical and bureaucratic fraternity dealing with health and development and understand their concerns and functioning systems. Our perspective of holism and totality need not limit itself to the cultural holism of a community but need to encompass all forces which are actively involved in planned change.

Although, it took about 20 years of gate crashing with the medical field for me and colleagues like Susan Scrimshaw to gain acceptability, the demands from the medical fraternity and health buraucracy are now too many to meet. However, we continue to be reactive and not proactive, inspite of our strengths in qualitative methods and theories relating to culture and culture change. We have to give further analysis of the dissociation between culture and life style which in a traditional society have been co-terminus. We have our friends in the medical world in the areas of epidemiology, psychiatry, community health,

particularly dealing with women's and child health.Our specialization about tribal people and culture would be very helpful in areas of tribal health which is a political priority in India. The term Scheduled tribe is a constitutional label, the ethnic tribal groups with their socioeconomic and cultural disparities being the ground level reality which need to be appreciated for microplanning and implementation.The chronic disease management issues which have more socioeconomic consequences, such as leprosy, TB and now HIV-AIDS and their combinations, and family welfare issues in their comprehensive and holistic relationship with development need anthropological interventions.

Indigenous communities and people no longer want to remain indigenous. They want change on par with so-called mainstream society. We have to go beyond evaluation research and take on the challenges of intervention research. Ethnographic documentation has to give way to analytical research combining the quantitative and qualitative data, although ethnography including the genealogies continue to be effective tools of data collection. I tried to involve the anthropology departments in leprosy research, but I have met with failure. I wonder whether our anthropology colleagues suffer from the stigma syndrome or are afraid of getting afflicted. We should consider ourself lucky that we get an opportunity to use our knowledge for the betterment of the lives of disadvantaged people, thanks to our discipline Anthropology. Now that the Public Health Schools are proliferating very rapidly in India, medical Anthropologists are in demand to do everything in teaching and research in the area of 'Public' in Public Health. Medical Anthropology does not become a social work discipline but with its theory and methodology, it has the prospect of becoming a profession.

I hope and wish SIMA to take initiatives in networking of medical anthropologists and health scientists in departments of Anthropology and in health and medical institutions, the Anthropological Survey of India and health administrators in the private and public sector, under the wider umbrella of INCAA which has emerged as a viable forum of anthropologists in India.

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Anthropology and Health Sector

Paper presented at National Seminar on "Nation Building : Anthropological Perspective and Contributions", Mysore

Introduction

Health matters have been considered as biomedical phenomena. However, people have varying beliefs and practices about personal body image, nutrition, causation of diseases, environment including plant and animal life, and fire and water. There are varying practices having a bearing on health which relate to personal hygiene, mating patterns, child birth and child rearing, age and sex groupings, social regulations of interpersonal and group contacts, family relationships and occupation structures. These cultural beliefs and practices and many others make health a social-cultural phenomena.

Health refers to the total fitness of an individual which would ensure performance of social roles to his optimum efficiency. All societies equip their members, through the processes of socialization and enculturation, to play useful roles commensurate with statuses. Societies provide institutional structures to look after the sick with a view to minimize the period and extent of disability and maximize the quantum of recovery in shortest possible period. All societies provide for sick roles since they cannot afford to lose the productive and role playing manpower through premature deaths or by falling victims to various diseases. Societies would obviously be more concerned with chronic, communicable diseases but the efforts to control these would be constrained by the knowledge about health and diseases in a society, by the capacity of the people to do organizational effort and by economic consideration.

Health and Culture

Health is an aspect of Culture like economic, political, social and religious aspects of life. Culture being an integrated whole, all aspects are interrelated. In any traditional society, the integration is close knit, the static or equilibrium spirit overriding the dynamic nature of culture. Health aspects could be classified into softer or visible aspects such as ill health or disease, which needs treatment. Ideas about prevention and promotion of health and causation of illness are part of hard core of culture, which would fall in the area of belief. Cause effect relationship about health and illness therefore fall in the areas of belief system. The plural treatment therapies, which may be herbal or of synthetic drugs in modern medicine, are guided by results. Magico-religious procedures are also followed in health, more so in tribal society, but not totally absent from the developed societies. There is no vacuum of knowledge or practices in matters of health and medicine in any society. There are professionals in tribal society, generally referred to as Bhagats who have good knowledge of herbal medicine, besides practicing magico-religious procedures. Tribal people have faith in them since they are a part of the community and are always available.

Development of the concept of welfare state has led the state to assume the responsibility of health of the people. Concepts of health, disease and treatment based on modern biology and modern medicine have created structures and organizations for healthcare, as we witness them today across the world. Traditional medicine has been reduced to the label of alternative medicine.

Community development programme in 1952 which was a major exercise in planned nation building had Health as one

of the prime components. Primary health centers were established as an aspect of community development. Anthropologists were called upon to educate illiterate communities to change their behaviour and attitudes, in order to accept modern methods of agriculture, health care and disease cure systems. Plethora of KAP studies indicated the research role of Anthropologists in documenting the baseline information and subsequent change. "India's Changing Villages" by S.C. Dube was one of the first books on community development. Anthropologists like Oscar Levis, David Mendelbaum, George Foster and Morris Oplar came as consultants in this process. The basic paradigm was that people needed to change their behaviour and comply with modern science and technology for their own development and for nation building. Anthropologists thus got the role of social marketing agent of modern science and technology. Traditional medicine was ridiculed as quackery and the concepts of hot and cold, and light and heavy were made fun of.

It has been seen that the leprosy control programme has not been addressing itself to the concerns of the people which pertain to fear of social death as a result of deformity. The programme addresses itself to the infection control model based on chemotherapy. The same kind of paradigms are also proposed in the areas of tuberculosis and population control. Operational research is meant to suggest logistic efficiency within a framework based on paradigms of infection control or concerns of the policy planners. We all witness the failure or unsatisfactory performance of all development and disease control programmes. This gives rise to the new slogan of community participation and community involvement. However, these terms convey the same old concern of policy planners about community

compliance. Compliance studies form substantial research material in disease control publications. We have found similar terminological changes in family planning and maternal health. Anthropology has now found fresh relevance due to primary health care approach in Alma Ata document highlighting importance of intersectoral coordination, which is enshrined in the integrative nature of culture.

In sexuality studies, it has been found that people associated TB with loss of immunity as a result of indulgence in sex. Since HIV has a direct relation with sexual route of transmission, people's ideas on the relationship of sex and immunity get strengthened. The concept of body and metabolism and immunity in Ayurveda and Unani are related to people's expressions. In India vasectomy could be a major political issue dislodging Prime Minster Indira Gandhi from power. Concern of the adolescent boys about masturbation and loss of semen is summarily rejected in the government training material. People's acceptance of modern diagnostic methods and modern treatment has been misconstrued as acceptance of modern science. Anthropologists do analyse disease causation theories and relief from any form of treatment as hard and soft core of health culture respectively, treatment being the soft and material aspect of culture.

Health education has sometimes been counter productive. The stigma in leprosy has been associated with deformity and not with the anesthetic patch which is one of the early signs of leprosy. Health education has contributed in bringing stigma to patch since the patch is labeled as leprosy. Till few years ago, condom was being propagated for contraception. Now, forgetting that role, condom is being promoted for safe sex

to prevent HIV infection. How are the people expected to respond to these shifts and to accept everything that comes in the name of modern science only to be changed in a short time?

The western world is now shifting towards alternative medicine, thanks to American medical system governed by insurance companies. People are tired of the side-effects of modern medicine and unnecessary and expensive use of diagnostic tools and techniques in the absence of clinical acumen on the part of the physician. In India, the traditional pharmaceutical interests are now demanding land in tribal belts for producing medicinal plants for production and export.

At Lahore Congress of the Indian National Congress around 1930, it was decided to accept Ayurveda and other Indian systems of medicine as national health systems after Independence. We are aware that after Independence, modern medicine has become the national health system. Officially plural systems of medicine exist in India by way of medical colleges, research institutes, pharmaceutical industries, and Government departments in all systems under the umbrella of AYUSH,Central Council of Indian Medicine, Indian Council of Medical Research,Medical Council of India and the like. However, the budgetary provision and the infrastructure of public health care delivery system clearly indicates bias in favour of modern medicine. Indian Systems of Medicine do not figure in Primary Health Centres.

Health and Health Care in Tribal Areas

Tribal health issues are inseparable from livelihood issues. Their food, nutrition, water, obstetric practices, disease care systems are a part of their adjustment with local environment. Universal value systems of humanity and civil society expect

us to help them to live longer, leading a creative life, to enjoy the freedom of choices in life. All societies including our own suffered from high mortality, epidemics and communicable diseases. Scientific advancement made it possible to reduce mortality and enhanced life expectancy in the world and in India.

The tribal people interact closely with local healers, the spirit world and use herbs for treatment and cure. Due to improved roads and transport, communicable diseases get transmitted to erstwhile virgin areas that have led to epidemics of measles resulting in child mortality. Due to depletion of forests, depriving the tribals of roots, tubers and animal life, nutrition standards have decreased. Primitive subsistence economy posing problems of survival has resulted in seasonal migration. The malnutrition and under-nutrition, and lack of health care facilities result in increased morbidity and mortality. Child deaths due to malnutrition in recent years has become an explosive issue in tribal health.

Government of Maharashtra has accepted deaths of 1034 children in the age group of 0-6 years in the tribal area of Nandurbar district from March 2000 to February 2001, 594 being children under 1 year of age. 76% of the siblings of dead children were found to be malnourished, indicating malnourishment as the cause of death, although 35% of dead children were reported suffering from diarrhoea and vomiting according to mothers.

The Tribal Research and Training Institute, Pune, Government of Maharashtra, conducted a study under the direction of Government of India to investigate the causes of deaths of tribal children in large numbers and suggest remedial measures. Accordingly, 158 child deaths from 143 families below the age of 6 years in 24 villages in Akrani, Akkalkuwa and Navapur

tehsils of Nandurbar district were investigated.

The fact finding study reported that 78% of the households had a food deficit of 6 months or more and had less than 3 acres of land and about 40% had less than 1-acre land or were landless. Faults were identified in the EGS and in reaching the health care to the people, particularly to pregnant women. Recommendations have also been made in the report on agricultural rehabilitation, on employment, public health and participatory planning etc. The studies have identified very frequent transfers of PHC doctors, indebtedness due to procurement of food as predisposing factors besides lack of nourishment to pregnant women .

One of the prominent silver lining in tribal culture and tribal health is the sex ratio. In Nandurbar, there are 966 females to 1000 males in the age group of 0 – 6 against the average sex ratio of 917 in Maharashtra. There is no female foeticide among the tribal people.

Special scheme for tribals: Nav Sanjeevan Yojana (NSY)

Nav Sanjeevan Yojana has been instituted with a focus on reducing the prevalence of infant and child mortality in tribal areas. The NSY includes the following main components: -

1. Matrutva Anudan Yojana (Maternity benefit scheme): A tribal pregnant woman is given Rs. 400 in cash when she reports for ANC and Rs. 400 by way of medicines, which are mostly tonics in syrup form.
2. Dai training: Dais conducting the delivery are given a one day orientation every three months and are paid Rs. 50 per training day.

3. Pada health worker: A community member mostly male is appointed during monsoon to undertake water disinfection, distribute chloroquin and ORS to patients and report outbreak of epidemic to PHC. He is paid Rs. 300 per month.

4. Compensation for loss of wages to the parents of Grade 3 and Grade 4 malnourished children for treatment at the PHC or rural hospital.

Besides, there is provision for appointment of honorary doctors for health check up of mother and child in every pada/ village and examining children at Anganwadi. The ICDS, EGS, Grain bank schemes have also been brought under NSY. The collector of the district under Tribal Sub-plan area acts as the chief implementing officer assisted by Chief Executive Officer of Zila Parishad, District Health Officer and Project Officer of Integrated Tribal Development Programme.

It is necessary to train more women from tribal areas in reproductive child health practices. Actually all women gram panchayat members, all women teachers, all girl students from Ashram schools, particularly, girls' Ashram schools in the age group of 12 and above could be trained in RCH. If we really care for women's health, all women volunteers from villages and hamlets could be trained in obstetric, pediatric and gynaec issues, in batches. Women are the custodians of family health in general and children's health in particular. Household therapies are also practiced by women under the guidance of elderly women, Bhagats and peer advice. The information about health and health care has to be more directed to women according to the principles of modern medicine and Ayurveda. Tribal health culture will change only if women accept the modern scientific methods of health care.

The local professionals, the Bhagats should not be ignored since they are part of the local community available all the time to the people. They would welcome training in Ayurvedic principles and would be willing to learn processing of local herbs into medicine since the folk knowledge and practices are the little traditions, which have synthesized in the great textual tradition of Ayurveda. The B.A.M.S. doctors can communicate with the Bhagats, more effectively unlike the M.B.B.S. doctors.

ICDS scheme is very good but the worker is burdened with too many records and registers. Anganwadi workers have shown good output in all their work as volunteers. Traditional midwife is another useful category. New volunteers could be recruited in this category and hamlet howsoever small may be her work area.

There are no programmes of nutrition education. Promotion of poultry, fisheries which are dear to tribals could find favour with tribals, which would supplement nutritious diet. People who go for work in Navapur tribal area were seen on road carrying food in tiffin containers. They could also be motivated to carry water. It was an experience to see several cases of adult diarrohea in PHCs and RH since the farmers took water from ponds close to their fields in monsoon.

As mentioned earlier, issues of food security, livelihood, migration and child deaths or morbidity during migration are interconnected phenomena. It is for this reason that Tribal Development Department and ITDP/TSP have been formed. However, **the sectoral administration is not sensitive to the distinct and integrative nature of tribal issues**.

Conceptual approach to Action strategy for Tribal development:

Tribal development strategies cannot be the same as that of development of the mainstream society. Tribal cultures due to historical and geographical reasons are distinct cultures and are more closely integrated wholes. Theory of culture, integration of culture and its implications for change indicate that change in one aspect of culture cannot be implemented with success without understanding the implications of change in other aspects. More closely the integrated cultures like the traditional tribal cultures, more difficult they are amenable to change with conventional sectoral interventions. Tribal cultures are labeled as primitive and backward since they do not change easily in spite of establishment of development infrastructure.

There are perennial debates whether tribal poverty is distinct from rural poverty in general. Since tribal cultures are close-knit integrated systems, the issues of livelihood, health and education cannot be separated for designing action strategies for development. The holistic approach to development, which is also called comprehensive development, envisages different action strategies.

World Health Organization's 'Health for All' declaration (Alma Ata, 1978) is based on the primary health care approach highlighting inter-sectoral co-ordination, whereby interventions in non-health development sectors such as education, transport, communication, electricity, food and water would ensure better health to the people.

Anthropological research approach is based on winning the confidence of the people by sharing their lives and concerns

for about a year, which is a unit of life. This helps understand the culture and concerns of the people from their perspective. The programmes of change and development have therefore to provide experience of results to the people, such as curing the morbidities of women and children. People change their attitudes and participate in development efforts if the programmes address to their concerns and provide experience of solution to their problems.

The strategies for tribal development do not visualize a multiplication of the government sector. Sustainable tribal development and culture change is achievable only by strengthening the people's sector involving Panchayati Raj institutions and people. The basic approach to tribal development therefore lies in capacity building of the people, which essentially becomes a programme of human resource development.

Action Strategies for improvement in health status:

Confidence building of the people

Tribal people have been living under adverse circumstances in hostile terrains developing coping mechanisms for resolving their health and illness problems. For a long time they lived in a time freeze and relied on the magico-religious practices and herbal remedies offered by the Bhagat. Their health care concerns have been managed by the benevolent and evil spirits and by white and black magic. Low birth weight babies have therefore been preferred for safe delivery instead of risking a woman's life in labour through acceptance of foetal growth interventions. Infant mortality therefore would be tolerated in preference to maternal mortality. It has always been customary in all traditional societies to follow the biological cycle of

reproduction and allowing the natural cycle of fertility and mortality by marrying at the onset of puberty. People are pragmatic in finding mechanisms of treatment and cure, which are time tested and which are available and affordable in the neighbourhood. Traditional medicine and practitioners continue to provide services to the people. People have to have experience of cure from modern medicine, which would be available and affordable. Tribal people have never sought any facilities apart from what is offered to them by nature and indigenous knowledge. Modern health care facilities and personnel need to reach out to the innocent, tradition bound, tribal people and provide them experience of relief from morbidities and risk situations.

The bottomline in dealing with the tribal people, who have experienced exploitation through contact with the outside world of literates, is that they need to get experience of successful treatment management and cure, which would develop their confidence in the government health care system. Tribal society is a close-knit kinship society. In a village, or within a radius of ten to twenty kilometers people of one tribal ethnic group are all related to each other, either through marriage or through lineage ties. The life experiences are thus shared. Even a Bhagat is a close kin of a large number of families. The acceptance and utilization of modern health care facilities require experiences of success.

Community participation

In order to strengthen democracy, 73rd amendment of the constitution provided more authority to Panchayati Raj Institutions and to the Gram Sabha, particularly in tribal areas. It is envisaged that some programmes like maternity benefit scheme and ICDS could be implemented by the Gram Panchayats with adequate

financial powers to do so. Every Gram Sabha could have a health agenda and the Bhagat as expert member of the community could be oriented to play an important role in health monitoring. There has to be a village health committee. Panchayat members, other village level functionaries could be oriented to health issues and made aware about the traditional and modern knowledge, which would help to develop plural health care system at the village level.

Summary

The crucial issue is to address the concerns of the people in terms of policies, implementation and logistics, to gain and instill confidence among them in the government system. These concerns are most explicit in issues of subsistence and morbidity, which relate to issues of 'health' and not only those of 'health care'. Thus, health refers to inter-sectoral development, while health care involves sectoral issues under the purview of the health department.

The prime health concerns of the tribal people are:

(a) Safe delivery having implications for maternal mortality.

(b) Child survival / preventing infant and child mortality.

(c) Food Security closely linked with migration.

How are existing schemes and institutional infrastructure addressing these concerns? What are people's experiences about livelihood, health, mortality and morbidity, which have shaped their attitudes and coping mechanisms? People would prefer infant mortality to maternal mortality. Babies cannot be saved where the terrain is hostile, transport not available and referral hospitals lack facilities and specialists like pediatrician,

obstetrician and anesthetists. Impractical schemes like Maternity benefit (Matrutva Anudan Yojana) whereby a pregnant woman is to be provided tonics and vitamin syrups, instead of food proteins and oil fat, and a cash incentive, which is seized by the husband, cannot deliver desired results. Our research concerns of increasing the birth weight of babies by providing nutritional supplements may not match the concerns of the people, who prefer low birthweight babies for safe delivery, in the absence of access to hospital assistance.

Anthropologists all these years kept quiet under the garb of value neutrality, 'a stance which tacitly becomes pro-establishment and anti-change'. The strong point of Anthropology is its holistic approach and in trying to understand the people's perception which are necessary for participatory democracy and sustainable development. The universal values about freedom from hunger and disease have to be implemented by adopting anthropological approach which Nehru labeled as 'developing according to the genius of the people'. The anthropological approach of looking at health and development issues from their perspectives would fecilitate finding solutions including the use of technology which would be acceptable to people, ensuring community involvement in the activities for change.

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Inter-Religious Dialogue and Infectious Diseases: The Point of View of Hinduism

Paper presented at XXI International Conference on "The Pastoral Aspects of the Treatment of Infectious Diseases", Vatican

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Slide 1

Inter-Religious Dialogue and Infectious Diseases: The Point of View of Hinduism

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Slide 2 : Hinduism

- Concept of one God. He created Universe (non- duality).
- "Truth is Religion and God" – said by Mahatma (meaning 'great soul') Gandhi.
- Truth shall Prevail ('Satyamev Jayate')
- Supreme aim is 'Moksha' – merging of soul with the holy spirit.
- Provision of Rebirth for spiritual progression towards Divinity.
- Freedom from rebirth would free the soul ('Moksha').

Slide 3 : Ayurved - Science of Life

- Hindu medicine is 'Ayurveda' – Science of Life.
- Four Vedas – Rigveda, Samveda, Yajurveda, Atharvaveda. Ayurveda - sub-discipline of Atharvaveda.
- Universe – all objects, all beings and Man made up of five elements: Ether, Air, Fire, Water, Earth ('Panchabhuta').
- Human body maintains health through seven metabolic processes during digestion of food – digested essence, blood, flesh, fat, bone, marrow, seminal fluid (seven 'Dhatu').
- Disease and illness is caused by disequilibrium among these seven 'Dhatu'.

Slide 4 : Life style

- Individual body-mind constitution ('Prakriti').
- 'Prakriti' influenced by three humours ('Dosha'): Wind ('Vayu'), Bile ('Pitta'), Phlegm ('Kapha').
- Human beings are categorized as per habits, temperament -Enlightened and Peaceful ('Satvic'), Fiery and Impulsive ('Rajasic'), Slothful and Ignorant ('Tamasic').
- Health maintained by pursuing righteous conduct (Dharma). Duties, obligations as per status and vocation through stages of life ('Varnashrama'), through pursuit of daily life style(Dinacharya) according to seasons (Ritucharya) in terms of food, exercise, rest, prayer, sex regulations.
- Deviant behaviour, disharmony causes disequilibrium and disease.

Slide 5 : Immunity

- Concept of immunity - internal body-mind and moral strength, overrides the concept of infection.
- Poverty, food insecurity, mental stress affect immunity of body.
- Viral diseases managed by lay persons by propitiating God. Idols in Hindu temples are only symbols of God.
- Most prayers of lay people seek health, happiness and material security, not affluence.
- Attending to old parents considered spiritually superior than attending to God, who prefers to wait eternally.

Slide 6 Illness : A Disharmony of the Inner Being

- Hinduism emphasises on prevention of disease, through righteous conduct to maintain body- mind harmony and equilibrium of the internal and external elements, which regulate body.
- "An illness of the body is always the outer expression and translation of a disorder, a disharmony in the inner being ; unless this inner disorder is healed, the outer cure cannot be total and permanent".
- The Mother (Mirra Alfassa), French companion of Sri Aurobindo, Pondicherry, India.

Slide 7 : Chronic Infections and Stigma

- Leprosy – Great Disease; T.B. – King of Diseases.
- Chronic diseases like leprosy needed divine intervention in the past, divine blessings with medication now. Continue to be stigmatised due to fear of deformity resulting in social exclusion.
- HIV / AIDS is more feared, with leprosy stigma transmitted to HIV. People seek more information on HIV. HIV-AIDS projected as synonyms.
- Rural lay people fear HIV infection of their adolescent children due to rural-urban migration for employment, occupational mobility and urban anonymity.
- Women suffer HIV due to men. They are drawn in commercial sex due to poverty.

Slide 8 : Photograph of Gandhi

Mahatma Gandhi nursing Parchure Shastri, the great Sanskrit scholar, who suffered from leprosy

Slide 9 : Preaching about Action

- In Hindu faith there is a concept of destiny leaving happenings to will of God. Feared to promote pessimism, fatalism. Obstructs positive action.
- Lord Krishna preached: Perform deeds Righteously as ascribed, but renounce the results of action ('Karma Yoga') – Bhagvad Gita. God will determine results.
- Coping mechanism: Death of a body is considered as a stage in spiritual path of soul. Immortal soul enters some other body through rebirth, until it is freed from rebirth.
- For action, Swami Vivekananda established Ramkrishna Mission for humanitarian social service in health, education and disasters.
- Mahatma Gandhi preached and practised Naturopathy, sanitation, treatment of leprosy, eradication of untouchability and alcoholism, empowerment of women, health education, nutrition, diet, regulation of sex. These issues became national programmes.

Slide 10 : Conclusion

- Ayurveda, Hindu medicine becoming secular therapy at global level for treatment of diseases. Yoga therapy also becoming secular using the parameters of modern pathology.
- Due to increase in transport and instant communication, contrasting forces - those of consumerism and pleasure here and now; and organized religious activities around temples and religious festivals, are on the increase.
- Epidemic communicable diseases are on the decline, but HIV/AIDS – T.B. co-infections are on the rise. These are challenges to spiritual, moral preachings and activities. Temple priests and religious leaders have more responsibilities now than before.

Slide 11 : Invocation

To seek Holy Spirit is to be moral and truthful.

Om Sarve Bhavantu Sukhinah
Sarve Santu Niraamayaah

May All Be Happy ; May All Be Healthy

Thank you

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Philosophical Basis of Hindu Medicine

Paper presented in XXI International Conference on "The Pastoral Aspects of the Treatment of Infectious Diseases", Vatican

Hindu medicine is known as Ayurveda, the science of life. The union of body, senses, mind and soul constitutes life. Vedas revealing the eternal truth are four: Rigveda, Samveda, Yajurveda and Atharvaveda, Ayurveda being a sub-discipline of Atharvaveda. Hinduism as a faith is difficult to define, it has no founder. Mahatma Gandhi defines Hinduism as the religion of Truth. According to Jawaharlal Nehru, its essential spirit seems to be to live and let live. There is concept of one God who created the universe, and is known as philosophy of non-duality (*advait*). The highest goal for a Hindu is merging of soul with that of the Almighty. Since this is not possible in the practical world of life, in one birth, there is provision for spiritual progression towards divinity, through series of rebirths, till the soul is freed, meaning attainment of Moksha (Salvation). The union of human soul and holy spirit is also termed as Yoga. Swami Vivekanand explains Yoga as union of all existence. Ayurveda and Yoga are practised as therapeutics.

India has accepted Mahatma Gandhi's moral, religious ideology of 'Truth is Religion and God' in its motto: Truth shall Prevail (*Satyamev Jayate*). Another principle preached and practised by Mahatma Gandhi, that of good of all (*Sarvodaya*) was enshrined in his 18 Constructive Programmes which encompassed four health programmes including sanitation and leprosy.

Ayurved System of Medicine

Ayurved philosophy is based on the concept about the perception of physical world through five senses, sight, hearing,

smell, taste and touch which are respectively located in the eye, ear, nose, tongue and skin. Universe as also human body is made up of five elements (*bhutas*): Ether (*akasa*) by sound, air (*vayu*) by touch, fire (*agni*) by light, water (*ap*) by taste and earth (*prithvi*) by smell. The substances which make food, drink or medication also consist of these five elements. The five elements co-operate together to uphold the body which consists of seven metabolic processes in the course of digestion of food (*dhatu*) viz digested essence (*rasa*), blood (*rakta*), flesh (*mamsa*), fat (*medas*), bone (*asthi*), marrow (*majja*) and seminal fluid (*sukra*). The vitality or inner strength which provides halo around the face is called *ojas*, the result of the proper proportion of the seven 'dhatu' strengthened by moral and spiritual behaviour. Any disequilibrium in five elements and seven *dhatu* creates disease and illness. The individual identity of body and temperament constitution (*prakriti*) is also determined by the *dosa* (humours), *vata* (wind), *pitta* (bile) and *kapha* (phlegm) which are internal waste products from the unabsorbed portion of food after digestion. Every individual may have the combination of *dosa*, one of them predominating over others. Food and medicines are also classified according to *dosa* and are prescribed accordingly for treatment. The interplay of *dosa* and disequilibrium causes illness which is set right by a physician through medication and regulation of diet, exercise and rest etc.

Briefly, Ayurveda as a system of medicine, concerns itself with the five elements (*bhuta*), seven *dhatu* and three *dosa* in body, mind and in food and drugs. Yoga concerns itself with mind and self (soul), with their effect on body. The ultimate cause of most illnesses are relegated to the imprudent behaviour rooted in the mind. Great emphasis is laid on the daily regimen of life varying as per climatic seasons about diet, exercise,

rest and regulation of sex. The message is, follow the nature, be symbiotic with nature. Mahatma Gandhi preached and practised naturopathy for prevention and treatment of illness.

In Ayurveda, there is no concept of external agent such as virus or bacillus causing illness. The reason why some persons get the disease and not all, exposed to bacilli or viruses, lies in the loss of immunity or internal strength to fight or resist the disease , due to deviation from righteous behaviour (dharma). Tuberculosis could be caused due to over indulgence in sex. Cause of leprosy was supposed to be rooted in sin either in this birth or last birth. In the absence of MDT modern medicine, leprosy was considered incurable or difficult to cure and needed divine intervention for cure.

Hindu Philosophy and Practice for Common Man

Bhagvad Gita, the 'Song of the Lord' which is a treatise of philosophy for common man advocates three paths to approach God. "These are the way of *karma*, performing action while renouncing the results of the action; the way of *jnana*, that of knowledge, and the way of *bhakti*, that of devotion." All people are classified according to habits and temperament; enlightened and peaceful (*satvic*), fiery and impulsive (*rajasic*), and slothful and ignorant (*tamasic*), in spiritual ranking. Foods are also classified accordingly. Gita has addressed more on mental health, preaching deeds (*karma*) according to righteous conduct (*dharma*).

The central concept of morality ensuring spiritual progression relate to truthfulness and righteous conduct according to one's position in life as an individual or as a member of a social or occupational group. The concepts of Varna and Caste are

based on this principle. The individual life is governed by the four stages of life (*Ashrama*), each one having socially approved obligations and code of conduct. A householder (*Grihasthashram*) is enjoined to indulge in sex for procreation but not the other three ashrama (*Brahmacharyashram, Vanprasthashram, Sanyasashram*). One has to earn livelihood through righteous means. Deviant behaviour is sinful, immoral and may result in disease and illness.

Viral diseases like small pox, chicken pox, measles were treated by propitiating the God. God for the common man became a deity and an idol in a temple. The Sanyasi (monk) who was supposed to have controlled the senses blessed the temple idols, since the disciples showered on them the best of all the articles of human enjoyment: foods, clothes, music and ornaments.

Incurable diseases like leprosy were supposed to be handiwork of evil spirits or the wrath of God due to immoral deviant behaviour. The stigma of leprosy is now being shifted to HIV/AIDS. Attending a patient and those engaged in healing are considered to be pursuing the work of God, among the Hindu. Mahatma Gandhi personally massaged the limbs of a leprosy patient in his hermitage. Attending to the health and well being of old parents is ranked high as equal to devotion to God.

All Hindu prayers, of whatever duration, solicit good health and material prosperity for the family, from the God. Many persons performing miracles to cure patients are understood to be possessing spiritual powers to do so. They follow a rigorous regimen of prayers and puritan life.

Hindu philosophy has been translated into practical humanitarian work in the 20th century by persons like Swami Vivekananda who established Ramkrishna Mission. Mahatma Gandhi combined the freedom struggle in India with constructive programmes giving more importance to means than the ends. The Sanyasi (monk) Ramdeo is currently preaching yoga therapy for chronic incurable diseases and showing results according to modern pathology parameters. He is propagating the glory of Yoga and righteous behaviour (*dharma*) according to the universal values enshrined in all religions.

Conclusion

The effects of globalization, and economies based on war machines, as also popularization of junk foods, pollution of environment, has increased morbidity in human society. It appears that simultaneously there is increasing interest in Ayurvedic and yoga therapy which are becoming secular in nature. Profit driven economy widens the gap between the rich and the poor, and the women take the beating by way of HIV infections. Since Hinduism is not a formal religion, but a way of life upholding righteous conduct (*dharma*) and Truth, examples of Swami Vivekananda, Mahatma Gandhi and now Swami Ramdeo could show the path of health and peace.

The message of Hinduism to prevent and treat infectious diseases could be harmony and equilibrium with nature, with oneself, through righteous behaviour, and urge to seek the universal Holy Spirit.

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The Social Responsibility of Social Scientists

Editorial published in Social Science and Medicine

In a recent editorial Peter McEwan[1] mentioned a remarkable disinterest in the topic 'The social responsibility of social scientists', at an international conference. This prompts the question why only tow participants should have been sufficiently interested to select this vital theme for discussion.

It appears obvious that social scientists are concerned about value neutrality and ideology which may go with the concept of social responsibility. Western anthropologists traditionally studied peoples of the Third World, documenting their cultures. Kinship, religion and traditional economic activities preceded documentation over ethnomedicine. Health activities and practices were grouped with religion and material culture. Western health care technology had reached these countries to protect the troops from disease in the cantonments, which diffused to the civilian population. Third World countries, after becoming independent, borrowed models of development from the capitalist or socialists West, in some cases mixing the two. Technology for controlling communicable diseases was also borrowed, together with the ideas and strategies of community development. Technologies for increasing food production were quickly accepted, having a demonstrable effect. People do not accept health technologies unless experiencing the beneficial effects for some time. Curative technologies are therefore accepted more easily than preventive ones. Moreover, existing

traditional health beliefs are likely to contradict or conflict with the concepts of modern medicine.

Health administrators in developing countries have been concerned about behavioural bottlenecks delaying the spread of modern concepts of health. There have also been problems in training a large army of paramedics to carry health care to the villages. Doctors and more particularly paramedics shared the health culture of the community which then had to be modified through comparatively brief training. Social scientists were drafted in an attempt to convince the illiterate about the scientific efficacy of modern health concepts. As with the training of paramedics, health education was conceived that would miraculously change people's behaviour in favour of modern medicine. The help of social scientists was therefore sought to increase compliance to technological interventions in modern medicine. In health related research or intervention programmes, social scientists have been positioned in a subordinate position to health professionals. Since the help was initially sought by health professionals, the objectives and goals were inevitably set by them.

The Alma Ata declaration on Primary Health Care proved a turning point in the interaction between social scientists and health professionals. The emphasis on intersectoral coordination and the development of non-health sectors for their impact on health sector, as also the emphasis on community participation, self-help, traditional medicine and appropriate technology, all provided an independent role for social scientists. However, the initiatives continued to come from the health professionals, with positions for social scientists being created in medical colleges and health institutions. Social scientists continue to

collect baseline information, to become involved in training and to undertake evaluation research in developing models of health development programmes.

George Foster [2-4] has written widely on the mistake of anthropologists treating communities responsible for the non-acceptance of modern health technologies. He has suggested that health bureaucracies need to be studied as they are most responsible for its failure of health programmes. Foster is thus making a value judgment in favour of the community while finding fault with health administrators for not planning and implementing the programme in accordance with the culture. Can it be said that he is not discharging his social responsibility ?

In developing countries like India, Medical pluralism exists in full form, at all levels. There are medical colleges, research institutes, pharmaceutical industries and government departments in all systems including Ayurveda, Unani, Homeopathy, Naturopathy, Yoga and Siddha, besides modern medicine. The public sector health care delivery system is dominated by modern medicine but other systems are making steady inroads. As a result, there are conflicts and confrontations between plural medical systems. Patients decide for themselves what is good for them in various disease conditions. What is the social responsibility of social scientists in such situations? Who should decide what is good for the people?

The main problem appears to be that the initiative to involve social scientists in health programmes comes from health professionals. They complain that social scientists do only post mortem research but shy away from action. While all medical research is intervention research, there are non interventions in the social sciences. In developing countries, scarcely any

funding is available without direct intervention. Some attempts have been made by social scientists to work as facilitators developing social action for example in leprosy. Social action has been referred to expanding the capabilities of health workers, patients and the community to play roles that would make them autonomous from health services. These refer to helping or empowering the community and groups to identify, understand, analyse and solve their own problems. The emphasis has been on learning through action in place of health education. Social scientists can play a useful role in building up such capabilities. They could also demystify their theory and research methodology in order to encourage participatory research.

Value neutrality tacitly supports stability and the establishment. Can culture-specific social dynamics by value neutral ? Social responsibility may refer to positions which are closest to people's thinking and culture. Debate on the theory and methodology of the social responsibility of social scientists is desirable. In developing countries, the non-government sector is fast expanding in all areas of health, development and research. NGOs seek intellectual support in planning, implementation and research from university-based social scientists. University structures being rigid, social scientists prefer to work with NGOs or to form their own NGOs.

Where is the thin line between social action and social responsibility ? Can social scientists keep themselves aloof from social action and face the charge of being self-centered, not discharging their social responsibilities, not putting their knowledge to the good of the people ? Even in the developed world, if the majority of people are denied access to health care which they cannot afford, is it not the social responsibility

of social scientists to suggest workable alternatives ? Such issues need to be documented and discussed.

Can social scientists play the role of social judiciary? Can they play the role of facilitators considering the universal acceptance of the Alma Ata declaration on primary health care? Answers to these questions need to be attempted by documenting various experiences of social scientists who work with government and NGOs in the health sector.

References

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2. Foster G. M. Applied anthropology and international health: retrospect and prospect. *Hum. Organiz.* **41,** 189- 197, 1982.

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ANNEXURE

List of Ph.D's in Medical Anthropology and Health Sciences under the supervision of Prof. R. K. Mutatkar

MEDICAL ANTHROPOLOGY

1. Joy C. Kurian – Culture and Mental Health : The Cultural Etiology of Mental Disorders in Rural Maharashtra.
2. B. R. Pathan – Stigma in Leprosy.
3. Robin Tribhuvan -- -Ethno-medicine: A symbolic system (study among the Thakurs)
4. S. N. Morankar – Cultural Determinants of diarrohoel illness : A study of village Community.
5. John Gaikwad – Cultural Profile of Health in a Tribal Community.
6. Susan J. Hansdak – Cultural Explanation of a chronic Disease; Leprosy.
7. Sunanda Bhagwat – Culture and Technology – (Studies in Tribal Technologies in Maharashtra).
8. Aarti Kaulagekar – Reproductive Health Behaviour of Women (A Study among Brahmin women at Pune).

HEALTH SCIENCES

1. D. S. Phalgune – Lifestyle and Health (Studies of University Students).
2. Hemant Apte – Adolescent Sexuality among rural migrant youth in Pune city.
3. P. S. Agashe – Sexuality and Sexual behaviour of Tribal males.
4. Arati A. Kelkar – Women, Education and Reproductive health Behaviour – A study from Kerala.
5. Abay Kudale – Study of Sexual Behaviour of Migrant Population from Velhe block, Pune.
6. Maushami Joshi – Sexuality of Adolescent Girls (Study from low-income group settlements in Pune city).
7. Father Ousepparampil Sebastian – An Integrated Approach to Medicine.

Prof R. K. Mutatkar a student of Prof S.C. Dube at Sagar worked at the University of Pune during 1960-1995. He worked with Dr. Irawati Karve and was the first Head of the Department of Anthropology at the University in 1977. He started teaching of Medical Anthropology in India in 1974 and hosted the International symposium in Medical Anthropology in 1978 as a post-plenary session of International Anthropology Congress at New Delhi. He was commissioned by WHO in 1981 to write a working paper on Social and Economic Aspects of Leprosy to start the research process on Social aspects of Leprosy which oriented the policy about prevention of deformities and identifying rehabilitation as an objective of leprosy control. He was invited by the Pontifical Academy of Sciences, Vatican to discuss social issues in Leprosy in 1984.

As convener and nodal person of the UGC Panel and Curriculum development committee, a new orientation for inclusion of Medical Anthropology and other applied aspects has been provided in the UGC curriculum of Anthropology.

He established Maharashtra Association of Anthropological Sciences in 1976, an academic NGO and functioning as friend, philosopher, guide to smaller NGOs involved in tribal issues, besides initiating research on health and development issues.

Prof Mutatkar with the support of Prof A.L. Basham, Prof Charles Leslie and Pandit Shiv Sharma helped to establish Indian Association for the study of Traditional Asian Medicine in 1980. He has worked on all the committees of the Government of Maharashtra regarding pseudo-tribal issues for the last 20 years and has been the chairman of the Backward Class Committee of the State Government.

Prof R.K Mutatkar established the Inter-disciplinary School of Health Sciences at the University of Pune in 1991 supported by Prof P.V. Sukhatme and became the first coordinator of the School. He has to his credit 18 PhD students in Anthropology and 7 in Health Sciences. His prominent books are *'Caste Dimensions in a Village'*, *'Society and Leprosy'* and an edited volume on *'Sexuality and Sexual Behaviour: Social Science Perspective'*.

For the first time AYUSH has been brought in Public Health fold in his capacity as chairman of the Working Group of Planning Commission for the XI Five Year Plan

Currently he is directing an intervention project on Comprehensive and Sustainable Human Development of the tribal people of Maharashtra in seven districts, jointly with Dr. R.S. Arole. He is chairman of the Ethics Committee of National AIDS Research Institute (NARI).

ABOUT MAAS

Maharashtra Association of Anthropological Sciences (MAAS) is an academic non-governmental organization based at Pune, Maharashtra in Western India. Since 1976, it has functioned through three arms, Centre for Health Research and Development (CHRD), Centre for Tribal and Rural Development (CTRD) and Centre for Documentation and Dissemination (CDD). MAAS is involved in training in research methodology, health and development through course work, seminars, symposia and workshops. It undertakes basic and intervention research in the areas of public health and development through holistic perspective. MAAS strives to use knowledge for understanding and proposing solutions to human problems in tribal, rural and urban communities. Through its activities, MAAS has been bringing together policy planners, administrators, activists and academicians to discuss issues around gender, culture, environment, health and education in the perspective of development. MAAS has organic links with the University of Pune and other academic and research institutions in India.

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